

EMERGENCY ROOM HISTORY & PHYSICAL

DATE SEEN: 01/18/2003

PATIENT NO: 000230073728

DATE OF BIRTH: 02/11/1997

HISTORY OF PRESENT ILLNESS: This is a nearly 6-year-old white male who was brought to the emergency department by his father with a complaint of an anoxic event. The father states that the patient was at home and he subsequently found the patient wedged in between areas of an exercise machine. He was unconscious; he was cyanotic and not breathing. Father states the patient possibly was unattended for 5-10 minutes at the most. He subsequently grabbed the patient from this position and extricated him and as he was running up the stairs with the patient, the patient began to breathe somewhat and also to moan and cry. He subsequently called 911. The EMS state that when they arrived, the patient was crying and agitated, nonverbal, was pink and perfusing well. They subsequently transported the patient with an IV line established. The patient had been in his normal state of good health prior to this, as per the patient's father.

PAST MEDICAL HISTORY: Negative.

PAST SURGICAL HISTORY: Negative.

REVIEW OF SYSTEMS: As above. Otherwise, negative.

NATAL HISTORY: He was a full-term gestation. He did stay in the hospital for two weeks for immature lungs, but has had no ongoing lung problems since that time.

EMERGENCY DEPARTMENT COURSE AND PHYSICAL EXAMINATION:

GENERAL: Upon arrival, the patient was crying and flailing his extremities about, but was nonverbal. His eyelids were closed, and he would not open them to any requests. Upon opening his eyelids manually, his pupils were dilated and nonreactive to light. The patient would withdraw all four extremities purposefully to painful stimuli. His head was atraumatic, normocephalic, nontender.

NECK: Supple. Full range of motion. Nontender. No palpable deformities.

BACK: Nontender, no abrasions.

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CHEST: Clear to auscultation. Good air exchange. No retractions.

CARDIAC: Regular rate and rhythm. No murmurs, rubs or gallops.

ABDOMEN: Soft. Nontender. Nondistended. No hepatosplenomegaly. No guarding or rebound. No masses or bruits. Bowel sounds present.

PELVIS: Stable, nontender.

EXTREMITIES: No cyanosis, clubbing or edema. No Homans' sign. Nontender.

NEUROLOGICAL EXAMINATION: As stated above.

HISTORY: Demonstrated what appeared to be a very fine petechial rash across the face. There was no subconjunctival hemorrhage. The pharynx was moist without stridor. When the patient initially arrived, he was in this state and subsequently was given 0.5 mg of Ativan in his line that was established by EMS; however, it was determined that this line was actually infiltrated, so this first half of a mg of Ativan was probably subcutaneous. The patient subsequently had another IV established in the emergency department by us in the right forearm and was given a further 0.25 mg of Ativan. At 2105 hours, he was more sedate. At 2114 hours, his pupils were 4 mm and slightly reactive at this point; however, his mental status was still unchanged. At 2130 hours, the patient was in CAT scan. At 2155 hours, he continued to be resting more comfortably, mental status still unchanged. Glasgow coma scale was estimated to be 9.

I did speak with Children's Hospital physician, Dr. Chaddha at 2117 hours, he did accept the patient to the Children's Hospital of Pittsburgh Emergency Department. I did advise him that LifeStar in Erie was ready to fly the patient at 2116 hours, and he was agreeable to let them fly the patient down. Of note, early in the patient's emergency department care, I had spoke with the Hamot intensivist, Dr. De Joya at 2114 hours. He stated that given the fact that there was no pediatric intensivist at Hamot that a flight to a tertiary care hospital for this patient's management would be most appropriate. The patient's father was agreeable with this transfer and did sign consent for this. LifeStar subsequently did arrive in the emergency department at 2155 hours and given the fact that the patient had just had an emesis, decided to intubate the patient to protect his airway. They did proceed to do this and subsequently transferred the patient to Children's Hospital of Pittsburgh.

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The patient received a total of 1 mg of Ativan prior to his disposition from the emergency department and then subsequently did receive some I medications by LifeStar prior to the intubation.

LABORATORY & X-RAY DATA: Included a portable chest x-ray which was negative for active disease, but did show a large amount of gastric air. This was read by me. CT scan of the head was no radiographic abnormality; this was the official report. White count was 14.0 with a normal automated differential. Hemoglobin was 11.3. Platelets were 464,000. Sodium was 139, potassium 3.3, chloride 100, bicarbonate 23, BUN 17, creatinine 0.5. Calcium was 9.0. Glucose was 169.

FINAL DIAGNOSIS: Anoxic encephalopathy, traumatic asphyxia, secondary to accidental chest wall compression.

DISPOSITION: The patient was LifeStar'd to Children's Hospital of Pittsburgh's Emergency Department for definitive treatment of his hypoxic encephalopathy. I provided this patient of one hour of critical care.

Peter M. Intrieri, MD

PMI/ara

cc:

PATIENT NAME Lord, Ryan C	DICTATED BY Peter M. Intrieri, MD	N.P. NO. 38-27-39	ROOM ED ED-018	DISCHARGE SN
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